United Nations ST/IC/2009/4

Secretariat

8 January 2009

English only

Information circular*

To: Members of the staff at offices away from Headquarters

From: The Controller of the United Nations

Subject: **Vanbreda medical, hospital and dental insurance programme for staff members away from Headquarters**

I. Costing of the Vanbreda programme

1. The Vanbreda programme is a self-funded health benefit plan. It is not an insured programme. As such, all costs of medical services received by staff members are borne by the United Nations and by plan participants through a 50:50 cost-sharing arrangement approved by the General Assembly.[1] The cost of the programme is entirely based on the medical services provided to staff members and directly reflects the level of utilization of the plan by plan participants. The yearly contributions paid by the plan participants and the portion of the premium paid by participating United Nations entities are used to cover claim costs plus a 10 per cent administrative fee payable to Vanbreda International (VBI).

2. Vanbreda International is not an insurance company but rather a provider of benefits consultants and administrative services. The United Nations has an administrative services only (ASO) contract with Vanbreda. Under the ASO arrangement, the United Nations uses Vanbreda's eligibility and claim processing expertise and benefits from discounted services that Vanbreda has negotiated with its international providers.

II. Renewal provisions for 2009

3. There will be a 5 per cent increase in the premium on 1 January 2009 (see paras. 10-13).

* Expiration date of the present information circular: 31 December 2009.

[1] See resolution 1095 (XI) of 27 February 1957.

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4. Programme changes beginning 1 January 2009:

(a) Mammography and prostate-specific antigen (PSA) screenings will form a part of "annual routine physical exams";

(b) Annual routine physical exams will be covered at the rate of 80 per cent, up to a maximum of $500;

(c) Reimbursement of hospital accommodation (bed and board) expenses will be subject to a daily room rate cap of $750 for the cost of a semi-private room in Europe (including Malta, Cyprus and the European part of Turkey), Canada, Israel and Australia; and $400 for the cost of a semi-private room in Chile;

(d) Prior approval from Vanbreda medical consultants is required for all non-emergency hospitalizations.

III. Other important information for 2009

Vanbreda eligibility applies for residents of all nations except the United States of America

5. The Vanbreda programme covers staff members and former staff members who reside in all parts of the world, **except** the United States of America (see also para. 16). Staff members, former staff members and their dependants **who reside in the United States of America are not eligible for Vanbreda coverage**. The sole exception to this exclusion arises in the case of a dependent child attending school or university in the United States, who will be obliged to enrol in the health insurance coverage offered by the educational institution. In this case, the student's health insurance plan at the school or university will be primary and the Vanbreda coverage will be secondary.

Annual enrolment campaign in 2009

6. Eligible staff members are reminded that the 2009 annual enrolment campaign will offer the only general opportunity in 2009 to enrol themselves and eligible family members in the Vanbreda plan. The annual enrolment campaign for the Vanbreda plan for staff members assigned to duty stations around the world is scheduled to be held from 1 to 5 June 2009.

Vanbreda dedicated website/Vanbreda identification cards/official designation

7. Vanbreda has dedicated web pages (see http://www.vanbreda-international.com) in respect of the United Nations worldwide Vanbreda plan. The pages can be accessed by logging on with a personal reference number indicated on the Vanbreda membership card. The website provides details regarding:

(a) Benefits;

(b) How to arrange for direct billing;

(c) How to submit a claim and how to receive your settlement online;

(d) Provision for the downloading of forms, for example, claim forms;

(e) Contact information at Vanbreda;

(f) A provider list enabling a participant to select medical providers based upon location and medical specialization;

(g) Information on symptoms and treatment of some chronic diseases (diabetes, HIV/AIDS, Parkinson's disease, asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD)).

8. The Vanbreda identification card which is mailed to all participants enables a hospital or clinic to contact Vanbreda in order to set up a direct billing arrangement in respect of hospitalization or high-cost outpatient treatment. Participants who do not have an identification card should contact Vanbreda (see para. 48).

General administration

9. The existing rules and terms governing eligibility and enrolment for the Vanbreda plan are summarized in paragraphs 14 to 38.

IV. 2009 premiums

10. The premiums are based solely on the claims incurred by the participants in the United Nations programme, plus the appropriate allowance for the cost of administration. Since the claim costs are incurred in all parts of the world, they reflect varying price levels. Accordingly, three different premium rate groups have been established to enable the determination of premiums that are broadly commensurate with the expected overall level of claims for the locations included within each rate group.

11. The financial performance of the programme for the past policy period was not favourable because of increased utilization and because of an increase in the cost of services. Premiums will increase by 5 per cent for the Vanbreda worldwide plan, effective 1 January 2009, in order to cover the cost of the programme during the next policy period.

12. The cost of the Vanbreda health insurance programme is shared between the participants and the Organization and is based on the General Assembly requirement for an overall 50:50 cost-sharing relationship. Premium contributions of participants in the programme are determined by multiplying their medical net salary[2] by the applicable contribution rate (percentage) set out in paragraph 13 below. This is consistent with the methodology used in calculating staff contributions towards other United Nations insurance programmes.

13. The schedule of premiums that will become effective on 1 January 2009, as well as the related staff contribution rates, is set out in the table below.

[2] Medical net salary consists of gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment, as applicable. In no case will a staff member's contribution be greater than 85 per cent of the total premium for the relevant coverage type.

Type of coverage	Monthly premium (United States dollars)		Percentage of medical net salary	
	Effective 1 January		Effective 1 January	
	2008	2009	2008	2009
Rate group 1[a]				
Staff member only	118	124	1.57	1.54
Staff member and one family member	252	265	2.43	2.38
Staff member and two or more eligible family members	416	437	3.83	3.75
Rate group 2[b]				
Staff member only	203	213	2.41	2.36
Staff member and one family member	428	449	3.89	3.81
Staff member and two or more eligible family members	707	742	6.11	5.99
Rate group 3[c]				
Staff member only	195	205	2.51	2.46
Staff member and one family member	410	431	4.05	3.97
Staff member and two or more eligible family members	677	711	6.38	6.25

[a] **Rate group 1 includes**: all locations outside of the United States of America other than those listed under rate groups 2 and 3.

[b] **Rate group 2 includes**: Chile and Mexico.

[c] **Rate group 3 includes**: Andorra, Austria, Belgium, Crete, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey (European portion) and the United Kingdom of Great Britain and Northern Ireland.

V. Eligibility and enrolment rules

General rules

14. The annual enrolment campaign will offer the only general opportunity in 2009 for eligible staff members to enrol themselves and eligible family members in the Vanbreda plan. The annual enrolment campaign for the Vanbreda plan for staff members assigned to duty stations around the world is tentatively scheduled for the period from 1 to 5 June 2009. Please also refer to paragraphs 22-24 below.

15. Except for staff members whose duty station is within the United States and locally recruited staff members at duty stations where the medical insurance plan (MIP) is established, all staff members holding appointments of three months or longer under the 100 Series of the Staff Rules or one month or longer under the 200 Series of the Staff Rules may enrol themselves and eligible family members in the Vanbreda plan. Staff members holding appointments of limited duration of three months or longer under the 300 Series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are eligible to enrol in the Vanbreda plan. Internationally recruited 300 Series short-term staff and occasional workers stationed outside the United States who have a valid contract

and who have achieved a threshold duration of continuous active employment at a minimum of half-time for at least three months are also eligible to enrol in the Vanbreda plan.

16. Enrolment in the Vanbreda plan at the time of initial appointment must be accomplished within 31 days of the date of entry on duty for staff members employed under the 100 and 200 Series of the Staff Rules and for staff members holding appointments of limited duration. For 300 Series short-term staff and occasional workers, enrolment at the time of initial appointment must be accomplished within 31 days after achieving a threshold duration of continuous active employment at a minimum of half-time for at least three months. **Staff members are not eligible for coverage under the Vanbreda plan if they or any of their covered dependants reside in the United States.** For enrolment purposes, applicants will be required to present (a) a Vanbreda application form and (b) proof of eligibility in the form of a personnel action (PA) document provided by their respective personnel or administrative officers attesting to the current contractual status. The enrolment of eligible family members requires the provision of evidence of the status of such family members. In most instances, the necessary proof of eligibility will be contained in the personnel action form.

Eligible family members for insurance purposes

17. An "eligible family member" is a recognized spouse and one or more eligible children. The recognized spouse is always eligible. A child must be the natural-born or legally adopted child of the staff member, or a stepchild reflected in the Integrated Management Information System (IMIS) as a household member. A child is eligible to be covered under this programme until the end of the calendar year in which he or she attains the age of 25 years, provided that he or she is not married and not employed full-time. Disabled children may be eligible for continued coverage after age 25, subject to a determination of the disability by the Medical Services Division.

Change in residence or duty station

18. Staff members at United Nations Headquarters in New York have the option of enrolling in the Vanbreda plan while on assignment to a field office or mission outside the United States. Upon return to a United States-based assignment, these staff members must reapply for participation in a United States-based United Nations health insurance programme.

19. Staff members away from Headquarters in New York who are assigned to a post in the United States must enrol in a United States-based United Nations health insurance programme. When their residence in the United States ends, these staff members may reapply for coverage in the Vanbreda programme.

20. A change in coverage following a change in residence or a return from mission assignment will become effective the first day of the month after arrival at the new place of residence or duty station.

21. **Please note that there are circumstances in which your insurance cannot be automatically continued: for example, when your payroll office changes. For this reason, whenever your country of residence or duty station changes, it is important that you confirm with your personnel or administrative office**

whether you need to submit an application to continue (or change) your insurance.

Enrolment at times other than upon entry on duty

22. Staff members appointed under the 100 Series of the Staff Rules who have not enrolled themselves and eligible family members within 31 days of the date of their entry on duty have an opportunity once each year to do so, during the annual enrolment period (see para. 14). The effective date of insurance coverage for which application is made during the annual enrolment period is the first day of July.

23. Staff members appointed under the 200 Series of the Staff Rules (project personnel) are, under staff rule 206.4 (a), required to participate in a medical insurance programme provided by the United Nations unless exemption from such participation is expressly stated in the letter of appointment. Staff rule 206.4 (b) provides that such personnel, if appointed for a period of one month or more and participating in a medical insurance programme provided by the United Nations, may enrol their spouses and dependent children in the programme. Project personnel who have not enrolled their spouses and eligible dependent children in the Vanbreda plan at the time of initial appointment have an annual opportunity to do so. **In the case of project personnel, the annual enrolment opportunity occurs on the anniversary of their entry on duty, and insurance coverage for added dependants will be effective as of that date.**

24. **Staff members holding appointments of limited duration under the 300 Series of the Staff Rules who have not enrolled in the Vanbreda plan at the time of initial appointment because they maintain their own coverage have an annual opportunity to enrol in a United Nations programme. Their annual enrolment opportunity occurs on the anniversary of their entry on duty.**

25. At times other than the annual enrolment periods referred to in paragraphs 22 to 24 above, Series 100 and 200 staff members and their eligible family members may be enrolled in the Vanbreda plan **only** if at least one of the following events occurs **and** application for enrolment is made within 31 days of the event:

(a) Transfer from one duty station to another;

(b) Return from special leave without pay (see para. 31 below);

(c) Assignment to a mission under certain conditions (see para. 32 below);

(d) Marriage, birth or legal adoption of a child, for coverage of the related family member.

26. Loss of coverage under a spouse's health insurance plan by virtue of the spouse's loss of employment is considered a qualifying event for the purpose of enrolment in a United Nations plan. Application for enrolment in a United Nations plan under these circumstances must be made within 31 days of the qualifying event. In addition, application for coverage under this provision must be accompanied by an official letter from the spouse's employer, certifying the termination of employment and its effective date.

27. Staff members who can demonstrate that they were on mission or annual or sick leave during the annual enrolment opportunity period may enrol within 31 days of their return to their duty station.

28. Applications between enrolment opportunity periods based on circumstances other than those listed in paragraphs 25 to 27 above and/or not received within 31 days of the event giving rise to eligibility will not be receivable.

Commencement and termination dates of health insurance coverage

29. New coverage for a staff member newly enrolled in the Vanbreda plan commences on the first day of a qualifying contract. If the first day of a qualifying contract occurs later than the first day of the month, coverage commences on that day, or the participant may opt for coverage to commence on the first day of the following month. In no event can coverage commence prior to the first day of the qualifying contract. Health insurance coverage terminates at the end of the month in which the qualifying contract ends. The programme will cover treatment for illness that occurs within the period of the contract. Treatments for illness or a condition that occurs after the contract period are not covered. The only exception here is that if a contract terminates before the last day of a month, coverage will remain in place until the end of that month.

Staff transferred to another duty station

30. Staff members who transfer to another duty station but who did not have medical insurance prior to the transfer may enrol themselves and eligible family members in the United Nations health insurance plan upon transfer. The enrolment application must be submitted within 31 days of the date of transfer, and the effective date of coverage will be the transfer date at the new duty station. This provision applies also in the case of transfer to Headquarters, in which case the new enrolment must be in one of the health insurance plans offered at Headquarters. **Staff members are reminded that if a duty station transfer involves a change from one payroll system to another, a new application for insurance must be submitted in order for your insurance benefits to continue. If you do not submit a new application, your insurance will expire at the end of the month in which the deduction of monthly premium contributions ceases in the previous payroll system.**

Staff on special leave without pay

31. Staff members who are granted special leave without pay are reminded that they may retain health insurance coverage during such periods or may elect to discontinue such coverage for the period of the special leave, as follows:

(a) **Insurance coverage maintained during special leave without pay.** If the staff member decides to retain coverage during the period of special leave without pay, the Health and Life Insurance Section (if payrolled at Headquarters) or the relevant administrative office (if payrolled elsewhere) **must** be informed directly in writing by the staff member of his or her intention at least one month in advance of the commencement of the special leave. At that time, the office concerned will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage retained (both the staff member's contribution and the Organization's share, since no subsidy is payable during such leave);

(b) **Insurance discontinued while on special leave without pay.** Should a staff member decide not to retain insurance coverage while on special leave without

pay, no action is required upon commencement of the special leave. However, it is essential that he or she re-enrol in the plan within 31 days of return to duty. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan until the following annual enrolment opportunity period.

Staff members on mission assignment

32. Staff members going on mission assignment are entitled to the following special health insurance enrolment opportunity:

(a) Staff members who at present are **not** enrolled in the Vanbreda plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in the plan in these circumstances must be completed **prior** to the departure of the staff member on mission assignment;

(b) Staff members who elect to enrol in the Vanbreda plan in the circumstances set out in subparagraph (a) above forgo the right to make any further change during the annual enrolment period taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for those staff members to make any change in their insurance coverage will be at the time of the annual enrolment period of the following year;

(c) Staff members going on mission assignment who wish to enrol in the Vanbreda plan or change their present coverage, as provided above, must present evidence of the mission assignment and its duration to the Health and Life Insurance Section of the Insurance and Disbursement Service at United Nations Headquarters or to their administrative office, as the case may be.

Staff member married to another staff member

33. Staff members are reminded that in the case of a staff member who is married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member. Separate coverage at the single rate may be maintained. It should also be noted that if one spouse retires from service with the Organization before the other spouse and coverage is at the two-party or family level, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service. The spouse in active service must complete the appropriate insurance application form to ensure continuity of coverage for both self and spouse.

Staff members with dependants residing in the United States

34. **Staff members are reminded that the Vanbreda plan is designed to provide hospital, medical and dental coverage for participants residing outside the United States. Therefore, staff members residing outside the United States but with covered eligible dependants residing in the United States, other than school or university students with health insurance coverage offered by the educational institution, must enrol instead in a Headquarters health insurance programme. Please note that the Headquarters dental programme is separate from the medical programme. If dental coverage is desired, the dental portion**

of the group medical and dental insurance application form should be properly filled out.

Cessation of family members' coverage

35. The insurance office at Headquarters or the relevant administrative office should be notified immediately in writing if a family member has ceased to be eligible owing to changes in the staff member's family (for example, a spouse, upon divorce, or a child, upon his or her reaching the age of 25 years, marrying or taking up full-time employment). Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. The responsibility for initiating the resulting change in coverage (for example, from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. It is in the interest of staff members to provide this notification promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution that may result. Any such change will be implemented on the first of the month following receipt of notification. **No retroactive contribution adjustments can be made in the case of failure to provide timely notification of any change to the Health and Life Insurance Section or the administrative office.**

After-service health insurance

36. Eligibility rules for participation in the United Nations after-service health insurance programme together with related administrative procedures are set out in administrative instruction ST/AI/2007/3, dated 1 July 2007. Staff members **recruited before 1 July 2007** are reminded that, among the eligibility requirements for after-service health insurance coverage, they must be enrolled in a contributory United Nations health insurance programme at the time of separation from service and a minimum of 5 years of prior contributory coverage in a United Nations or specialized agency health insurance programme is necessary to qualify for unsubsidized after-service health insurance participation and a minimum of 10 years of prior contributory coverage is needed to qualify for subsidized participation. Staff members **recruited after 1 July 2007** are reminded that, among the eligibility requirements for after-service health insurance coverage, they must be enrolled in a contributory United Nations health insurance programme at the time of separation from service and a minimum of 10 years of prior contributory coverage in a United Nations or specialized agency health insurance programme is necessary to qualify for participation. In all cases, the staff member must be aged 55 years or over at the date of separation and must have elected to receive a monthly retirement benefit or deferred monthly retirement benefit from the United Nations Joint Staff Pension Fund (UNJSPF). It should also be noted that only those family members enrolled with the staff member at the time of separation are eligible for coverage under the after-service health insurance programme. Please take note that service under a 300 Series appointment of limited duration does **not** count towards eligibility for after-service health insurance.

37. Former staff members who reside in the United States are reminded that they are **not** eligible for participation in the Vanbreda plan and that they must switch to a Headquarters plan within 31 days of taking up residence in the United States.

Retirees who return to active service

38. Retirees who return to active service with the Organization may be temporarily ineligible for health insurance coverage under the United Nations after-service health insurance programme. This can occur if the monthly pension benefit is suspended because of resumed status as active staff. In such a case, eligibility to participate in the after-service health insurance programme is suspended while pension benefits are suspended, because eligibility for after-service health insurance is contingent upon continued receipt of a monthly United Nations Joint Staff Pension Fund benefit. When this occurs, it is the obligation of the individual concerned to notify the insurance office promptly of the new active appointment and to make the necessary arrangements for a switch in health insurance enrolment from after-service health insurance status to that of an active staff member. If this is not done, the staff member will have no insurance. When the active appointment ends, the Health and Life Insurance Section must again be informed promptly so that the after-service health insurance status can be reactivated.

VI. Conversion privileges

39. A "conversion" privilege is part of the United Nations group contract with Vanbreda. This privilege allows staff members (subscribers) who cease employment with the United Nations and do not qualify for after-service health insurance benefits to "convert" their group medical insurance with Vanbreda to an individual short-term health insurance policy. The individual conversion policy is guaranteed-issue. This means that no proof of the subscriber's good health is required; the insurer cannot refuse to insure an eligible subscriber who applies in a timely manner for a conversion policy. Application for an individual policy under the conversion privilege must be made within 31 days of termination of coverage under the United Nations group policy. The availability of this privilege does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of the individual health insurance policy. **The conversion privilege is designed to provide coverage during a period of transition to more permanent health insurance coverage. The Vanbreda conversion privilege grants coverage up to a maximum of 36 months and is not subsidized by the United Nations.**

40. Staff members (subscribers) may apply for a policy of individual coverage under the conversion privilege for themselves only or for themselves and their covered eligible dependants. Moreover, eligible dependants may apply on their own behalf in the following circumstances:

(a) Children whose eligibility for insurance ceases as the result of reaching age 25 are eligible to apply for a health insurance conversion policy provided that they are financially dependent on their parent(s), are unmarried, and are not employed full-time;

(b) A staff member's spouse whose eligibility for insurance ceases as the result of divorce and who is not employed full-time may also apply.

The application for an individual conversion policy **must** be submitted within 31 days of termination of coverage under the United Nations group medical programme.

41. Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Vanbreda at the following address:

Vanbreda International
Plantin en Moretuslei 299
2140 Antwerp, Belgium

Tel: +32 3 217 5742
Fax: +32 3 272 3969
E-mail: gp1@vanbreda.com

VII. Claims and enquiries

Basis for claim reimbursement in United States dollars

42. The default currency for claim reimbursement is United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred.

43. Reimbursement in United States dollars is based on the United Nations operational rate of exchange in effect on the date that the medical and dental expenses are incurred and, in the case of hospital expenses and doctors' fees incurred during the hospitalization, on the date that the hospital bill is rendered.

44. As of 1 January 2008, Vanbreda International began reimbursing members in euros for costs incurred in euros and/or payments made in euros. For this purpose, Vanbreda International adapted its claim form. Please note that only one currency per claim form will be allowed and that if no reimbursement currency is selected on the claim form or if data are insufficient to provide the payment selected, reimbursement will, by default, be made in United States dollars.

45. In order to guarantee a smooth processing of their claims, Vanbreda International would like to encourage all plan participants, and certainly those that will avail themselves of the option of receiving reimbursements in euros, to use the settlement details online together with electronic fund transfers (direct deposit into the member's bank account).

46. The latest version of the claim form and more information on settlement details online can be found under "member's access" on the Vanbreda International dedicated web pages (see http://www.vanbreda-international.com).

Mailing addresses

47. Participants must inform their administrative office of any change in their mailing address in order to ensure that identification cards, reimbursements and explanations of benefits are delivered promptly and appropriately.

Where to address claims and benefit enquiries

48. Although the staff of the insurance office is available to assist staff members in administrative matters concerning participation in the Vanbreda plan, claims questions should always be taken up on the first instance directly with Vanbreda International. Information on the claims filing procedure and contact details can be

found under "member's access" on the Vanbreda International dedicated web pages (see http://www.vanbreda-international.com).

Claims address and enquiries about claims

Postal address: Vanbreda International, Postbox 69, B-2140 Antwerp, Belgium

Dedicated tel: +32 3 217 6842

In certain countries, Vanbreda International provides toll-free telephone lines. A complete list can be found under "member's access" on the Vanbreda International dedicated web pages (see http://www.vanbreda-international.com) or in annex IV to the present document.

Fax: +32 3 663 2855

Dedicated e-mail address: mcc001@vanbreda.com

Member services and general enquiries

Dedicated tel: +32 3 217 5742

In certain countries, Vanbreda International provides toll-free telephone lines. A complete list can be found under "member's access" on the Vanbreda International dedicated web pages (see http://www.vanbreda-international.com) or in annex IV to this document.

Fax: +32 3 272 3969

Dedicated e-mail address: gp1@vanbreda.com

Vanbreda International website

http://www.vanbreda-international.com

Availability of claims settlement details online

49. Vanbreda International offers the opportunity for members to receive their settlement details online. Applying for this service can be done on the Vanbreda International dedicated web pages under the section entitled "claims" (see http://www.vanbreda-international.com). In order to guarantee a smooth processing of claims, Vanbreda International would like to encourage all plan participants, particularly those that will avail themselves of the option of receiving reimbursements in euros, to use the combination of settlement details online and electronic fund transfers (direct deposit into the member's bank account).

24-hour customer service

50. Vanbreda International offers 24-hour customer service with its extended business hours in Antwerp, Belgium, and its service platform in Kuala Lumpur. Multilingual staff in both Antwerp and Kuala Lumpur have been specifically trained to respond immediately to all queries that United Nations staff members may have. The Vanbreda service platform has been organized so that the main international languages are accessible 24 hours a day.

VIII. Annexes

51. Annex I contains a summary of the benefits payable under the Vanbreda plan.

52. Annex II contains details pertaining to hospitalization in the United States of America.

53. Annex III describes the Vanbreda direct deposit programme.

54. Annex IV is a listing of Vanbreda International toll-free telephone numbers.

Annex I

Vanbreda insurance benefits summary

A. General

1. The Vanbreda insurance programme indemnifies members, within the limits of the plan, for reasonable and customary charges in respect of medical, hospital and dental treatment for illness, an accident or maternity. The aggregate reimbursement in respect of the total expenses covered by the plan that are incurred by an insured participant shall not exceed $250,000 in any calendar year. The provisions set forth below shall be subject to this limitation. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure, supplies or other services may also apply, depending on the type of service, as described in the paragraphs below.

2. The programme reimburses only treatment, supplies or other services that are widely and generally accepted as medically necessary and appropriate for the condition being treated, and when such treatment, supplies or other services are prescribed by a licensed, qualified medical professional. Vanbreda International has the fiduciary duty and discretionary authority to determine, on behalf of the United Nations, what constitutes a covered service or plan benefit under the programme.

3. Prior approval from Vanbreda medical consultants is required for all non-emergency hospitalizations. Prior approval means that reimbursement is guaranteed only in cases where, on the basis of the medical justification, as well as a cost estimate furnished by the beneficiary at least one week prior to the admission date of the hospitalization in question, Vanbreda medical consultants grant explicit approval for the treatment. In the case of a medical emergency, approval can be obtained post factum, on the basis of the same medical criteria. Other benefits that require the prior approval of Vanbreda medical consultants include acupuncture, speech therapy, home health care, durable medical equipment or orthopaedic appliances, and vitamins, minerals and food/nutritional supplements.

4. The United Nations health insurance plan provides for two levels of coverage, namely, the Basic Medical Benefit Plan (BMBP) and the Major Medical Benefits Plan (MMBP). Both the BMBP and the MMBP coverage periods run from 1 January until 31 December. Medical expenses are reimbursed under BMBP and MMBP. Services rendered by a licensed paramedical professional or, in case of maternity, by a licensed midwife can be considered for reimbursement, but only upon the prescription of a licensed, qualified medical professional. The major medical component does not apply in the case of dental treatment, outpatient mental health treatment, treatment for substance abuse (alcohol and/or drug), expenses for hearing aids, or expenses for optical lenses, nor does MMBP apply for costs that are reimbursed at 100 per cent under BMBP (for example, other hospital expenses and hospital stay), as there is no balance left on these charges. Also, expenses that are subject to a maximum reimbursement (for example, dental care, optical care, psychotherapy, etc.) are also not subject to a reimbursement under the MMBP component. MMBP covers 80 per cent of the difference between the accepted costs and the amount reimbursed under BMBP. In order to be entitled to any reimbursement under MMBP, a deductible of $200 per insured person or $600 per

family has to be satisfied. All payments under MMBP are applied automatically and do not require submission of a claim by the United Nations staff member.

5. **Reimbursement rates**

(a) Under the basic medical component, reimbursement in respect of medical treatment prescribed by qualified doctors is calculated at the rate of 80 per cent of the reasonable and customary charges involved, including inpatient and outpatient doctors' fees (see para. 35 below for information about reasonable and customary charges);

(b) Under the major medical component, 80 per cent of the residual unpaid reasonable and customary charges are paid, subject to a calendar-year maximum co-payment of $200 per participant and $600 per family. The calendar-year maximum co-payment is sometimes called the "deductible", requiring that the participant pay the 20 per cent residual out-of-pocket, up to the calendar-year maximum co-payment of $200, or $600 in the case of family coverage. When covered expenses exceed the calendar year maximum co-payment amount, the 80 per cent basic component still applies, and the major medical component automatically reimburses 80 per cent of the residual 20 per cent for the remainder of that calendar year.

6. **Example: medical expense reimbursement**. The following example illustrates how reimbursement is determined for an individual in respect of basic and major medical coverage (figures are in United States dollars):

(a) Basic coverage (BMBP)

Reasonable and customary charges for medical treatment	3 200
Reimbursement at 80 per cent	2 560
Residual 20 per cent	640

(b) Major medical coverage (MMBP)

20 per cent residual not reimbursed by basic coverage	640
Less calendar year maximum co-payment	-200
= Basis for major medical coverage	440
x 80 per cent = major medical reimbursement	352

(c) Total reimbursement (recapitulation of (a) and (b))

Basic medical coverage	2 560
Major medical coverage	+352
Total insurance reimbursement	2 912
Participant's total out-of-pocket expense	288
Total original expense	3 200

B. Hospital services and related care coverage

Inpatient hospitalizations

7. All non-emergency inpatient admissions must be pre-certified by Vanbreda medical consultants. An inpatient admission is defined as treatment, testing and surgery provided in hospital where the date of admission differs from the date of

discharge. The cost of the hospital expenses (excluding doctors' fees[a]) are covered at the rate of 100 per cent.

(a) Hospital expenses include bed and board, general nursing services, use of operating rooms and equipment, stay in the intensive care unit (ICU), use of recovery rooms, hospital equipment, laboratory examinations, medical imaging, and drugs and medicine used during the patient's stay in the hospital;

(b) Reimbursement of hospital accommodation (bed and board) expenses will be subject to daily room rate caps, as follows:

(i) 100 per cent of the cost of a semi-private room up to a maximum of $750 per day in Europe (including Malta, Cyprus and the European part of Turkey), Canada, Israel and Australia;

(ii) 100 per cent of the cost of a semi-private room up to a maximum of $600 per day in the United States of America;

(iii) 100 per cent of the cost of a semi-private room up to a maximum of $400 per day in Chile;

(iv) 100 per cent up to a maximum of $330 per day in the rest of the world;

(c) Only under the following conditions, and subject to the provision of documentation satisfactory to the insurer, will private-room accommodation be considered for reimbursement in full up to the above limits for admissions in the United States of America, Europe, Canada, Israel, Australia and New Zealand:

(i) When the nature and gravity of the illness requires private-room care and the need for such care is substantiated by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, that is, it has no standard of accommodation other than private rooms and general wards.

Inpatient treatment for alcohol and drug abuse

8. The cost of treatment for alcohol and/or drug abuse is covered if said treatment is considered to be medically necessary by Vanbreda International. Coverage includes inpatient treatment for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of Vanbreda International. Such treatment will be limited to 30 days in a calendar year.

Provisions pertaining to hospitalizations in the United States of America

9. Participants are free to seek admission to a hospital in the United States of America but will have to provide prior notification to Vanbreda. **Reimbursement for such hospitalization will be subject to a limit of $600 in respect of the daily semi-private room rate**. Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $600, the cost of the daily room rate above $600 will be borne entirely by the participant. There will be no change in the

[a] Doctors' fees incurred during a hospital admission are covered at 80 per cent + MMBP.

reimbursement for other services. Please note that hospital costs vary considerably throughout the United States and may exceed the $600 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C. Hospital costs also vary by institution and may be much higher in certain hospitals. The $600 limit will not apply in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States authorized by the United Nations Medical Director;

(b) In cases of bona fide medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can be provided only at a hospital where the daily semi-private room rate exceeds $600. In such cases, confirmation must be obtained from Vanbreda International prior to the hospital admission.

Outpatient surgery, chemotherapy, radiotherapy and haemodialysis undergone on or after 1 January 2007[b]

10. An outpatient admission is defined as a hospitalization where the date of admission is the same as the date of discharge. Hospital expenses resulting from outpatient surgery, chemotherapy, radiotherapy and haemodialysis rendered in an outpatient, ambulatory or day-surgery department in a hospital are covered at 100 per cent. The related doctors' fees (fees of surgeons, anaesthetists, treating physicians, midwives, etc.) are covered at 80 per cent + MMBP. Any take-home medication purchased during this outpatient admission will be covered at 80 per cent + MMBP.

C. Physician services and other medical benefits

11. Hospital expenses and doctors' fees incurred during an outpatient non-surgical admission (for example, for medical imaging, laboratory testing, etc.) will be covered at 80 per cent + MMBP.

12. Expenses related to medical treatment provided by medically qualified doctors are reimbursable at 80 per cent + MMBP. Expenses for paramedical treatments are also covered at 80 per cent + MMBP, provided that the treatment was prescribed by a medical doctor.

13. Physiotherapy is covered at 80 per cent + MMBP provided that the therapy is administered to improve or restore physical functions that have been lost or are debilitated as a result of an illness, accident or congenital disorder. Therapy aimed at preventing deterioration of bodily functions is not reimbursable. The doctor's prescription should clearly indicate the medical reason for which the therapy is being prescribed (that is to say, the diagnosis), the type of treatment prescribed, the number of sessions prescribed, and the period of treatment.

[b] Hospital expenses and doctors' fees incurred during an outpatient admission prior to 1 January 2007 will be covered at 80 per cent + MMBP.

14. Alternative medicine is covered under certain conditions provided that there is sufficient scientific proof of its therapeutic effectiveness. Requesting prior approval for alternative medicine is recommended.

15. Acupuncture is covered at 80 per cent + MMBP if it is provided to treat orthopaedic ailments or to alleviate pain. Vanbreda International medical consultants will determine whether the acupuncture performed for a specific diagnosis is reimbursable. The treatment should be given by a fully qualified acupuncturist. If the acupuncturist is not a medical doctor, the treatment needs to be prescribed by a doctor. The prescription should clearly indicate the type of treatment required, the diagnosis or the reason for the prescribed treatment, the number of sessions required, and the duration of the treatment.

16. Speech therapy[c] is subject to prior approval from Vanbreda International medical consultants. It is covered at 80 per cent + MMBP if it is provided to restore or improve the speech of patients who have speech/language disorders that are the result of a non-chronic disease or acute injury (for example, following a cerebrovascular accident, a tumour of the tongue, a thyroidectomy, a tracheotomy, etc.). The reimbursement of the expenses for speech therapy can also be considered if it is provided following a neuro-degenerative illness (for example, Alzheimer's disease), a speech delay (and/or learning difficulties) that is associated with a specifically diagnosable disease, injury or congenital defect (for example, cleft palate, cleft lip, dyslexia, autism) or speech and/or learning difficulties for children with dysfunctions that are self-correcting (for example, developmental articulation errors that are self-correcting). To allow Vanbreda medical consultants to grant prior approval for the therapy, the following documents must be submitted:

- A doctor's prescription specifying the medical reason for the treatment, and indicating the number of sessions or the period of treatment required
- A speech therapeutic evaluation
- The (para-) medical degree of the care provider

17. Podotherapy is covered at 80 per cent + MMBP if the therapy is medically necessary. The doctor's prescription should clearly indicate the medical reason for the therapy (that is to say, the diagnosis), the type of treatment prescribed and the number of sessions prescribed.

18. One initial consultation with a registered dietician is covered at 80 per cent + MMBP under the benefit for nutritional counselling. Participants with a body mass index (BMI) of over 30 or suffering from a relevant chronic disease (namely, cardiovascular disease, diabetes mellitus, hypertension, severe kidney insufficiency; an eating disorder; a gastrointestinal disorder) are covered for up to 10 sessions of nutritional counselling. The doctor's prescription should clearly specify the medical reason for the therapy (diagnosis), the number of sessions required and the (para-) medical degree of the care provider.

19. Home health care is covered at 80 per cent + MMBP provided the treatment is pre-certified by Vanbreda International medical consultants. Only medical care is eligible for reimbursement. Custodial care or assistance with activities of daily

[c] Speech therapy is not covered when it is provided to remedy dysfunctions produced by a multilingual environment, nor are motives for treatment based c.. social or educational concerns grounds for reimbursement under the plan.

living (for example, feeding, bathing, dressing, providing companionship) is not covered. The doctor's prescription for home health care must indicate the following:

- The patient's medical condition for which the attention of a home nurse is required
- The period during which the attention of a home nurse is required
- The treatment plan, including a list of tasks that the home nurse is expected to perform and the approximate amount of time required for each individual task

(a) The treatment should be given by a qualified and skilled nurse. The invoice should clearly indicate the following information:

- The paramedical degree of the person providing the care
- The dates on which care was given
- The various tasks performed on each date
- The amount of time needed for each task
- The fee charged per hour and the total fee

If extensions to these periods are needed, prior approval should be requested by sending detailed medical evaluation reports justifying the prolongation from a medical point of view.

(b) For home hospitalization services provided on or after 1 January 2007, expenses can be reimbursed at 100 per cent if home health care is provided as an alternative equal in cost to, or cheaper than, a medically required inpatient hospitalization. It is a requirement that prior approval for the home health care be obtained from Vanbreda International medical consultants. Approval will be given only for limited time periods.

In addition, the following maxima per illness apply:

- $10,000 for care given in Canada
- $7,500 for care given in Europe
- $5,000 for care given in the rest of the world

20. **Durable medical equipment and orthopaedic appliances**. The United Nations health insurance plan covers the rental of medical appliances at 80 per cent + MMBP (or the purchase thereof when purchase is more economical than rental or when it is impossible to rent the appliance in question), if considered medically necessary by Vanbreda International medical consultants. The rental (or purchase) of the appliance or equipment should be prescribed by a medical doctor and pre-certified by Vanbreda. The following documents must be presented for pre-certification:[d]

- A cost estimate
- A prescription indicating the medical necessity of the appliance/equipment, a description of the appliance/equipment and whether it should be rented or purchased, and the period of time for which the item is required

[d] This procedure is applicable for crutches, walking canes, hospital beds, nebulizers, oxygen apparatus and wheelchairs. If the item you require does not appear in this list, please contact us for further details.

(a) Glucometers and blood-testing strips are reimbursable only for insulin-dependent patients and must be pre-certified by Vanbreda International medical consultants. If approved, the cost involved will be reimbursed at 80 per cent + MMBP. Urine-testing strips are reimbursable in cases of diabetes regardless of whether the patient is insulin-dependent or not;

(b) Blood pressure gauges (sphygmomanometers) are excluded from the United Nations health insurance plan. In exceptional cases, the reimbursement of a blood pressure gauge can be considered for:

- Diabetics (both type I and type II, provided that the patient is taking medicines to control the illness, namely, insulin and/or oral antidiabetics)
- Pregnant women who present a clinical risk for developing toxicosis or pre-eclampsia
- Elderly people suffering from multiple co-morbidities
- Patients on home dialysis
- Patients with cerebrovascular malformations

(c) In addition, the self-measurement monitor should be standardized, validated and calibrated. Because of the above, the correct monitor should be leased out by the treating physician or medical institution and purchased only if there is no other alternative;

(d) Support stockings for varicose veins are covered at 80 per cent + MMBP if prescribed by a medical doctor and pre-certified by Vanbreda. The prescription should indicate the diagnosis for which the stockings are required as well as the number of pairs needed per year. Vanbreda medical consultants will then decide on the number of stockings reimbursable per calendar year;

(e) The cost related to the rental of a continuous positive airway pressure (CPAP) machine[e] is covered at 80 per cent + MMBP if pre-certified by Vanbreda and if either of the following conditions exist:

- The patient's apnea-hypopnea index (AHI) is equal to or greater than 15; or
- The patient's apnea-hypopnea index is greater than 5 and less than 14, and at least one of the following conditions is met:
  - Excessive daytime sleepiness (documented by either Epworth sleepiness scale score greater than 10 or multiple sleep latency test (MSLT) score less than 6)
  - Documented symptoms of impaired cognition, mood disorders or insomnia
  - Documented hypertension (systolic blood pressure greater than 140 millimetres of mercury (mm Hg) and/or diastolic blood pressure greater than 90 mm Hg)
  - Documented history of ischaemic heart disease
  - Documented history of stroke

[e] The costs related to the purchase of a CPAP machine can be considered only in countries where rental is not possible.

– Greater than 20 episodes of oxygen desaturation less than 85 per cent during a full night sleep study, or any episode of oxygen desaturation less than 70 per cent

21. **Medication**. Expenses related to the purchase of medicine are reimbursable at 80 per cent + MMBP, provided that the medicine was prescribed by a medical doctor. Medication can be covered only if it is required as a result of an illness, accident or maternity. The product should contain active medical components, and be generally medically recognized and fully approved by the relevant legislation in force. Each prescription should clearly indicate:

- The name of the patient requiring the medication
- The name of the product(s) prescribed
- The dosage required

(a) Vitamins, minerals and food/nutritional supplements are reimbursable at 80 per cent + MMBP if there is an existing deficit, which has been objectively proved by means of laboratory results, necessitating their use and if they are pre-approved. The name of the medication and the medical necessity for its use must be provided to Vanbreda in order for pre-approval to be obtained. Vitamins, minerals and food/nutritional supplements are excluded when taken for preventive reasons;

(b) Homeopathic medication is covered as indicated in paragraph (a) above;

(c) Phytotherapeutic and herbal products (for example, Chinese medicines), lotions, shampoos, soaps, skincare products, cosmetic products and creams, products based on mineral water and elixirs are excluded from the plan. Products aimed at suppressing hunger, quitting smoking or strengthening hair and nails, and hair growth products are not eligible for reimbursement;

(d) Viagra and other medications used to treat erectile dysfunction are covered at 80 per cent + MMBP provided that the product is prescribed by a medical doctor following a prostatectomy, and in the case of diabetic neuropathy. The prescription must include the patient's diagnosis. There is a maximum reimbursement for six tablets per month. Erectile dysfunction as a result of ageing and psychogenic impotence is not a valid condition with respect to satisfying the criterion for Viagra benefits;

(e) Weight-reduction medication (namely Xenical, Meridia and Reductil) is eligible for reimbursement at 80 per cent + MMBP if pre-certified by Vanbreda and if the following conditions exist:

- A body mass index (BMI) greater than or equal to 30, in conjunction with any of the following severe co-morbidities:
    1. Coronary heart disease
    2. Type II diabetes mellitus
    3. Clinically significant obstructive sleep apnea
    4. Medically refractory hypertension
    5. Well-documented and serious orthopaedic problems

Approval is granted for a limited period of time; for approval of the prolongation of the treatment after the time period has ended, an evaluation report on the effectiveness of the treatment (percentage of weight loss) needs to be submitted to Vanbreda medical consultants;

(f) Medication to treat osteoporosis (for example, Fosamax®, Actonel, Bonviva, Aredia, Evista sodium) is eligible for reimbursement at 80 per cent + MMBP if pre-certified by Vanbreda and if a medical report including the results of the initial bone mass measurement (BMM) (that is to say, before treatment started) mentioning the T- and Z-scores is submitted to Vanbreda International medical consultants. This type of medication will be covered only if the BMM results show that the patient is suffering from osteoporosis (that is to say, if the T-score is -2.5 or below and the Z-score is -1.0 or below). Reimbursement for such products is limited to a period of five years;

(g) Medication related to the treatment of HIV/AIDS is covered at 80 per cent + MMBP.

D. Outpatient treatment subject to certain limitations

22. **Dental treatment**. The cost of dental treatment is reimbursable at the rate of 80 per cent up to a maximum sum of $1,000 per calendar year per beneficiary. The cost of orthodontic treatment is covered only if the care is started before the patient has reached his or her fifteenth birthday. Reimbursement for such orthodontic treatment is provided only during a maximum treatment period of four years. For orthodontic treatment resulting from an accident, the age restriction does not apply.

(a) In the case of dental surgery performed in hospital for which an operating theatre is required, the surgeon's fees and the cost of the dental items are reimbursable at 80 per cent up to the $1,000 calendar-year maximum. The hospital expenses and bed and board expenses are reimbursable as indicated under inpatient hospitalizations;

(b) In the case of reconstructive dental or orthofacial surgery resulting from an accident, the ceiling can be waived upon prior approval from Vanbreda medical consultants. To claim reimbursement, one must submit a detailed original invoice stating the date(s) of treatment, the kind of treatment administered on each date, and the amount charged for each treatment.

23. **Outpatient mental health**. The cost of outpatient mental health services provided by a psychiatrist, a licensed psychoanalyst, a licensed psychologist or a licensed psychiatric social worker is reimbursable at 80 per cent, up to a maximum of $1,000 per beneficiary per calendar year, provided the services are considered medically necessary by Vanbreda. Expenses related to relationship therapy (for example, couple therapy) are not covered under the plan. To claim reimbursement, one must submit a detailed original invoice stating the date(s) of the session(s) and the diagnosis or reason for treatment.

24. **Hearing aids and optical care. The cost of hearing aids and optical care is covered if the member has participated in the programme for one year prior to the time of purchase.**

25. **Hearing aids**. The costs of hearing aids are reimbursable at the rate of 80 per cent with a maximum of $300 per apparatus, including the related examination, and a maximum of one apparatus per ear per period of three years. This period starts on the date of purchase of the first hearing aid. To claim reimbursement, one must submit the original invoice clearly indicating for which ear the hearing aid has been purchased and the doctor's prescription for the hearing aids.

(a) The date of the hearing test or the date of purchase, whichever comes first, is considered when determining the eligibility for reimbursement for the expenses in question.

26. **Optical care**. The costs of optical lenses (including contact lenses and disposable lenses) are reimbursable at the rate of 80 per cent (only basic coverage, no major medical coverage) with a maximum of $120 per two-year period. Frames are not covered under the plan. These maxima will also apply to surgical or laser treatment for the correction of refraction. To claim reimbursement, one must submit the original invoice clearly indicating the products purchased (for example, frame, number of lenses, contact lenses), the individual price of each item, and the dioptre of the lenses (that is to say, their strength or grading).

(a) The date of purchase is considered when determining the eligibility for reimbursement of the expenses in question; for example, if the cost of glasses purchased on 30 November 2007 was subsequently reimbursed by Vanbreda International, only the cost of a new pair of glasses purchased on or after 30 November 2009 will again be eligible for reimbursement. The cost of glasses purchased prior to this date will not be taken into account with respect to payment.

27. **Routine eye examination**. One routine eye examination to determine the dioptre is covered within a two-year period and will be reimbursable at 80 per cent + MMBP.

28. **Outpatient treatment for alcohol and drug abuse**.[f] The plan covers outpatient counselling for the purpose of diagnosis and treatment. The costs of outpatient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to the counselling of covered family members of the participant undergoing treatment for the substance abuse problem.

29. **Testing for the HIV virus**. The cost of two blood tests per year are covered at the rate of 80 per cent + MMBP if the test is performed on an outpatient basis or at 100 per cent if the test is performed as part of an inpatient hospital admission or outpatient surgery.

30. **Routine physical exam**. For expenses incurred on or after 1 January 2009, one prescribed and medically justified routine physical exam per person per calendar year is covered at the rate of 80 per cent up to a maximum of $500. This coverage includes related X-rays, laboratory and any other charges, urologic examinations and prostate-specific antigen (PSA) screenings, gynaecological exams, mammography screening and Pap smears. Exams prescribed to diagnose or treat a suspected or identified illness or disease will not be reimbursed under the routine physical exam.

[f] Inpatient treatments are reimbursable as indicated under inpatient hospitalizations.

31. Upon the recommendation of a physician, a mammogram may be covered for persons of any age who have a prior history of breast cancer or whose mother or sister has a prior history of breast cancer. Mammography screenings are covered whether carried out in a medical provider's office, hospital outpatient department, hospital ambulatory surgery department, or ambulatory surgery facility, or in another facility that is licensed to provide mammography screenings. The screening is covered at 80 per cent + MMBP.

32. **Well-child care/immunizations** will be covered at 80 per cent + MMBP in accordance with the following schedule:

- Well-child care to the age of 7 years:
  - Six visits per year aged 0 to 1 year
  - Two visits per year aged 1 to 2 years
  - One visit per year aged 2 to 7 years
- One visit every 24 months from age 7 to 19 years

33. **One annual influenza immunization** will be reimbursable at 80 per cent + MMBP. Prior to 1 January 2007, all preventive immunizations for adults were not reimbursable under the Vanbreda worldwide plan.

34. The cost of HPV vaccines (for example, Gardasil, Cervarix) will be reimbursable at 80 per cent + MMBP for girls up to the age of 19.

35. **Exclusions**. The insurance programme does not cover:

(a) Injuries as a consequence of voluntary or intentional action on the part of the insured participant;

(b) Insured participants who are mobilized or who volunteer for military service in time of war;

(c) Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(d) The consequences of insurrections or riots if, by taking part, the insured participant has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;

(e) Spa cures, rejuvenation cures or cosmetic treatment (reconstructive surgery is covered where it is necessary as the result of an accident for which coverage is provided);

(f) The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;

(g) Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded;

(h) In vitro fertilization;

(i) Frames for glasses;

(j) Periodic preventive health examinations undergone prior to 1 January 2007;

(k) Products and treatments aimed at suppressing the appetite or quitting smoking, cosmetic products or products used to stimulate hair and/or nail growth;

(l) Fitness and physical education programmes;

(m) Additional bed and board for an accompanying person during inpatient hospitalization;

(n) Educational tests and therapies;

(o) Preventive vaccines and medication for adults over age 19 (except for one annual influenza immunization);

(p) Expenses that are not deemed to be reasonable and customary;

(q) Medical care that is not medically necessary or medical care that is not medically recognized as a treatment for the diagnosis provided;

(r) Products, the effectiveness of which has not been sufficiently proved scientifically and which are not generally medically recognized in the medical world, are not covered under the health plan. One example of this exclusion are products containing glucosamine or chondroitin sulphate;

(s) Claims received by Vanbreda International later than two years after the date on which the expense was incurred;

(t) Elective surgery not resulting from illness, an accident or maternity;

(u) Cost of contraceptives, unless there is a medical indication necessitating their use. In this case, prior authorization from Vanbreda International medical consultants should be requested.

36. The determination of the reasonable and customary charge for each service is made by Vanbreda, based on the prevailing charges for the service at the place where treatment is rendered and considering the complexity of the treatment, including related services or supplies. Fees for treatments, supplies or services that are determined by Vanbreda to be excessive compared with prevailing fee levels will be reimbursed up to the reasonable and customary level for the geographical area in which such medical services are received.

37. Members are reminded that claims for reimbursement must be submitted to Vanbreda no later than **two years** from the date on which the medical expenses were incurred. **Claims received by Vanbreda later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Annex II

Provisions pertaining to hospitalization in the United States of America

1. Participants are free to seek admission to a hospital in the United States of America but will have to provide prior notification to Vanbreda. **Reimbursement for such hospitalization will be subject to a limit of $600 in respect of the daily semi-private room rate.** Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $600, the cost of the daily room rate above $600 will be borne entirely by the participant. There will be no change in the reimbursement for other services. Please note that hospital costs vary considerably throughout the United States and may exceed the $600 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C. Hospital costs also vary by institution and may be much higher in certain hospitals.

2. The **$600 limit will not apply** to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States where there is prior authorization by the United Nations Medical Director;

(b) In cases of **bona fide** medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can be provided only at a hospital where the daily semi-private room rate exceeds $600. In such cases, for the obligation of the participant to meet daily room-rate expenses in excess of $600 not to apply, specific confirmation that the daily limit does not apply must be obtained from Vanbreda prior to hospital admission.

3. Please note that staff members, former staff members and their eligible dependants who **reside** in the United States are not eligible for coverage under the Vanbreda plan.

Annex III

Direct deposit of reimbursements of claims into member bank accounts

1. Members are reminded of the option to have their reimbursements of claims deposited directly into their personal bank accounts. Direct deposits can be made in United States dollars and in euros. Please note that only one currency per claim form will be allowed and that if no reimbursement currency is selected on the claim form, or data are insufficient to provide the payment selected, reimbursement will, by default, be made in United States dollars. Election of this option can be made on the claim form that is posted on Vanbreda's dedicated website for United Nations participants (see http://www.vanbreda-international.com). Use of the claim form available on the Vanbreda website is recommended since it facilitates the settlement of claims by printing the participant's name and Vanbreda reference number as well as a corresponding bar code on the form. Although there is a Vanbreda claim form also posted on the United Nations insurance website (see http://www.un.org/insurance), it does not have the unique reference number or bar code.

2. Enter the following bank information on the Vanbreda claim form. Your bank can provide you with the information in (d) and (e):

(a) Bank name and full address;

(b) Bank account number;

(c) Account holder's name;

(d) International Bank Account Number (IBAN) code: mandated for cross-border payments within the European Union and Switzerland. If the IBAN is not available, provide the corresponding local bank code: for example, ABI/CAB for Italy, Bankleitzahl for Germany, sorting code for United Kingdom, and so on;

(e) Bank identification code: either the BIC/SWIFT code, or the ABA code in the United States.

3. Please note that the direct deposit option is not available for deposits into bank accounts in the following countries: Cuba, Iran (Islamic Republic of), Myanmar and the Sudan.

Annex IV

Vanbreda International toll-free telephone numbers

UIFN (universal international free phone number)

Please dial the access number for international calls in the country you are calling from and then dial the 800 number assigned for that country. For example, if you are in the United States, you would dial 011 (access number for international calls) plus 80082468866 (the number for the United States).

Country or area	*Type*	*Number*
Argentina	UIFN	+80082468866
Australia	UIFN	+80082468866
Austria	UIFN	+80082468866
Belgium	UIFN	+80082468866
Brazil	UIFN	+80082468866
Canada	UIFN	+80082468866
China	UIFN	+80082468866
Colombia	UIFN	+80082468866
Costa Rica	UIFN	+80082468866
Cyprus	UIFN	+80082468866
Denmark	UIFN	+80082468866
Finland	UIFN	+80082468866
France	UIFN	+80082468866
Germany	UIFN	+80082468866
Hong Kong, China	UIFN	+80082468866
Hungary	UIFN	+80082468866
Iceland	UIFN	+80082468866
Ireland	UIFN	+80082468866
Israel	UIFN	+80082468866
Italy	UIFN	+80082468866
Japan	UIFN	+80082468866
Malaysia	UIFN	+80082468866
Malta	UIFN	+80082468866
Netherlands	UIFN	+80082468866
New Zealand	UIFN	+80082468866
Norway	UIFN	+80082468866
Philippines	UIFN	+80082468866
Portugal	UIFN	+80082468866
Russian Federation	UIFN	+80082468866
South Africa	UIFN	+80082468866
Spain	UIFN	+80082468866

Country or area	*Type*	*Number*
Sweden	UIFN	+80082468866
Switzerland	UIFN	+80082468866
Thailand	UIFN	+80082468866
United Kingdom of Great Britain and Northern Ireland	UIFN	+80082468866
United States of America	UIFN	+80082468866

ITFS (international toll-free service)

Please dial the number.

Country	*Type*	*Number*
Chile	ITFS	12300208432
Mexico	ITFS	018001231680
India	ITFS	0008004401303
Indonesia	ITFS	001803440600
Sri Lanka	ITFS	2473018

TFD (toll-free direct)

How does it work?

AT&T Direct® Toll-Free Service is a two-step dialling process:

1. The caller first dials the AT&T Direct® access code for the country from which he or she is calling. The caller reaches an English-speaking (or selected in-language support, including Spanish) AT&T operator or voice-prompt and hears the following announcement:

"AT&T. Please enter the number you are calling now."

2. The caller enters the toll-free number. The AT&T operator services responds: ***"Thank you for using AT&T"*** and completes the call to the toll-free number location.

Country	*Type*	*Toll-free direct access code*	*Toll-free number*
Lebanon Beirut	TFD[a]	426 801	800 203 0939
Lebanon outside Beirut	TFD[b]	01 426 801	800 203 0939
Cambodia	TFD[c]	1 800 881 001	800 203 0939
Egypt Cairo	TFD[d]	510 0200	800 203 0939
Egypt outside Cairo	TFD	02 510 0200	800 203 0939

[a] Public phones may require local coin payment during call duration.
[b] Collect calling only.
[c] Available from payphones in Phnom Penh and Siem Riep only.
[d] Public phones require coin or card deposit.